NORTH CAROLINA
DIVISION OF MEDICAL ASSISTANCE
APPLICATION FOR PROVIDER PARTICIPATION
Personal Care Services

Provider Services 2501 Mail Service Center Raleigh, NC 27699-2501 (9l9) 857-4017

Individuals or organizations desiring to provide care or services to N.C. Medicaid eligibles must file an application for enrollment as a Medicaid provider and sign a provider agreement. Separate application, proof of authority to render the services, and a provider agreement must be provided for **each** business site. If prescribed conditions are met, a provider participation agreement will be executed between the provider agency and the Division of Medical Assistance. The enrollment process must be completed and the provider participation agreement approved prior to submitting claims for payment. Properly completed claims must be received within 365 days of the date of service or no payment will be made.

The following information must be supplied. If an item does not apply to your practice, agency or organization, enter N/A in the item. The application will supplement the approved provider agreement.

l. _____
Name of Business/Agency

_____
Site Address Phone No.

_____
City State Zip

_____
Mailing address if different from above

2. Type of Application
( ) Initial request
( ) Change in Ownership
( ) Reapplication
( ) Expansion of services

3. _____
Medicare Number

4. _____
IRS Tax Identification Number

5. Type of Provider/Agency:
( ) State/county govt. agency
( ) Partnership
( ) Corporation
( ) Individual
( ) Independent Laboratory
( ) Other _____

6. Ownership and Control Interest:
Complete for individuals and organizations having direct or indirect ownership or controlling interest. Percentages must equal l00%.

Name	Title	Address	Social Security #	Ownership %

7. Is the organization/agency incorporated?
( ) Yes. Attach copy of Articles of Incorporation, (this applies to all corporation types, LLC, PLLC, etc.)
( ) No.

8. Corporate Officers:
   List officers and directors of corporation.

Name	Title	Address

9. Have individuals or organizations having a direct or indirect ownership or control interest of 5% or more in this business been convicted of a criminal offense related to the involvement of such persons or organization in the programs of Medicaid (Title XIX), Medicare (Title XVIII) or Social Services Block Grant (Title XX)?
   ( ) Yes. Provide names in this space or attach documentation.
   ( ) No.

10. Have any directors, officers, agents, or managing employees of the agency or organization been convicted of a criminal offense related the their involvement in the programs of Medicaid, Medicare, or Social Services Block Grant?
    ( ) Yes. Provide names in this space or attach documentation.
    ( ) No.

11. Have civil monetary penalties ever been levied against this agency or organization by Medicare, Medicaid or other State or Federal Agency or Program? ( ) Yes ( ) No

    If yes, have all penalties been paid and satisfied? ( ) Yes ( ) No

12. In what specific locations or areas of the state will the service(s) be provided? _____

    _____

13. Is the agency or organization licensed, certified, accredited, or approved by any professional organization or Board?
    ( ) Yes. Attach copy of license, certification, accreditation, permit, approval, etc.
    ( ) No.

14. Has the license to provide Home Health PCS services for this facility been reissued in accordance with a purchase, assumption, or change in ownership or controlling interest of an existing agency? ( ) Yes ( ) No

    If yes, provide the name, address and Medicaid provider number of the previous PCS Agency.

    Name of Agency: _____ Address _____
    Medicaid Provider # _____ Date Agency purchased, assumed or changed Ownership: _____

13. SIGNATURE OF PROVIDER:

    _____
    Printed Name of Owner or Corporate Officer Title

    _____
    Signature of Owner or Corporate Officer Date